House Cities & Counties Subcommittee Am. #1

Amendment No._____

FILED
Date _____
Time _____
Clerk _____
Comm. Amdt. _____

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Signature of Sponsor

AMEND Senate Bill No. 2069* **House Bill No. 2296**

by deleting all language after the enacting clause and substituting instead the following:

SECTION 1. Tennessee Code Annotated, Title 9, Chapter 1, is amended by adding the following as a new section:

(a) As used in this section, "unborn children" means individual living members of the species homo sapiens throughout the entire embryonic and fetal stages of the individual living members from fertilization to full gestation and childbirth.

(b) Notwithstanding any other law, a county or municipality may, at its own expense, take a special census that includes unborn children in its population at any time during the interim between the regular decennial federal censuses. Such right includes the current decennium. The special census must be conducted in a manner directed by and satisfactory to the department of economic and community development. When taking the special census, an unborn child is identified on the census list as "Unborn Child (mother's last name)", and the unborn child's address is the address of the unborn child's mother. A municipality or county electing to conduct such special census shall certify the census results to the departments of finance and administration and economic and community development.

(c) Any state funds required by § 54-4-203, § 67-6-103, or other state law to be allocated and distributed to the several municipalities and counties within this state in the proportion as the population of each municipality or county bears to the aggregate population of all municipalities or counties within the state, must be allocated and distributed according to the last special census as authorized by subsection (b), if any

municipality or county has taken such census. The allocation and distribution of federal funds are not affected by the special census. For purposes of distributing and allocating state tax revenues or other state funds to the municipality or county, the municipality's or county's population must be revised in accordance with the special census, effective on the next July 1 following the certification of the special census results. The aggregate population of the county or municipality must likewise be adjusted in accordance with any such special census, effective the same date as provided in this subsection (c). If no such census has been taken, then the funds must be allocated and distributed according to the latest federal census and other censuses authorized by law or as otherwise provided in § 54-4-203, § 67-6-103, or other state law.

SECTION 2. This act shall take effect upon becoming a law, the public welfare requiring it.

House Cities & Counties Subcommittee Am. #1

Amendment No._____

FILED
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Comm. Amdt. _____
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Signature of Sponsor

AMEND Senate Bill No. 2310* **House Bill No. 2767**

by deleting all language after the enacting clause and substituting instead the following:

SECTION 1. Tennessee Code Annotated, Section 8-27-507, is amended by deleting the section and substituting instead the following:

(a) As used in this section:

(1) "Administrator" means:

(A) An individual, either employed by, or contracted with, the sponsor or the plan to provide administrative services on behalf of the plan; or

(B) An entity with whom the sponsor contracts to provide administrative services on behalf of the plan;

(2) "Days" means calendar days, unless otherwise noted;

(3) "Insured" means any individual, other than the primary insured, who receives benefits under the plan;

(4) "Plan" means any self-funded plan established and funded by a sponsor pursuant to this part for the purpose of providing group life, hospitalization, disability, on-the-job injury or work-related injury program, or medical insurance, where funding for the plan is derived from local tax revenues, which are used to either fully, or in excess of fifty-one percent (51%), fund the total costs of the plan, and where such benefits are paid directly through the sponsor's general assets or through a trust fund established for that purpose. Self-funded plans include those plans to which the primary insured pays to the plan a nominal fee, not to exceed a total of ten percent (10%) of the total cost of

coverage for the primary insured and any insureds whose relationship to the primary insured allows them to receive benefits under the plan. Whether or not the plan contracts with an administrator is not a factor in determining whether the plan meets this subdivision (a)(4);

(5) "Plan document" means a written instrument by which a plan is established and operated;

(6) "Plan participant" means either a primary insured or insured;

(7) "Primary insured" means the individual employed by, or contracted with, the sponsor and to whom, based on the individual's status as an employee or contractor, the plan provides benefits;

(8) "Settlement" means an agreement reached between a plan participant and a third party tortfeasor or the third party insurer, or both;

(9) "Sponsor" means any county within this state that establishes and funds a plan;

(10) "Subrogation interest" means the right to recovery that the plan has in any litigation or settlement arising from the injury or illness of a plan participant caused by a third party tortfeasor. "Subrogation interest" does not include pre- or post-judgment interest;

(11) "Summary plan description" or "SPD" means a summary of the plan document that includes, at a minimum, a summary description of all benefits and costs under the plan, including co-pays, deductibles and premiums for different tiers of coverage, if applicable; a list of eligible plan participants; contact information for the administrator; contact information for the sponsor; and a mailing address for each type of notice required by this statute;

(12) "Third party for medical services" or "third party" includes, but is not limited to, a health and liability insurer, an administrator of an ERISA plan, an employee welfare benefit plan, a workers' compensation plan, CHAMPUS,

Medicare, and other parties that are by statute, contract, or agreement, legally responsible for payment of a claim for a healthcare item or service;

(13) "Third party insurer" means any insurer that provides insurance coverage to a third party tortfeasor, regardless of whether such coverage is personal or commercial, including, but not limited to, automobile, income replacement, premises liability, home owners, umbrella, group life, health, workers compensation, hospitalization, and disability; and

(14) "Third party tortfeasor" means an individual or entity who commits a tort against a plan participant that causes a plan participant to require medical treatment for which the plan makes payments to a provider of medical services for the benefit, or on behalf, of the plan participant.

(b)

(1) A plan shall not recover a medical payment paid to, or on behalf of, a plan participant, under a plan unless the medical payment has been incorrectly paid, or unless the plan participant recovers, or is entitled to recover, from a third party tortfeasor or third party insurer reimbursement for all or part of the costs of care or treatment for the injury or illness for which the medical payment is paid.

(2) The plan is subrogated to all rights of recovery against any person or entity for the cost of care or treatment for any injury or illness caused by a third party tortfeasor for which medical payment is provided, contractual or otherwise, by the plan for the benefit of, or on behalf of, a plan participant.

(3) The plan shall not withdraw or reduce payments to a provider of medical services in order to recover funds obtained by a plan participant from third party tortfeasors or third party insurers for medical services rendered by a medical services provider if the plan has reason to know that such funds were obtained without the knowledge or direct assistance of the provider.

(4) If the plan asserts its right to subrogation, the plan shall notify the primary insured, in language understandable to the primary insured, of the plan's

rights of recovery against third parties and that the primary insured should seek the advice of an attorney regarding those rights of recovery to which the plan may be entitled. Such notice shall be made by certified mail, with a signed or electronic receipt, sent to the last address of record the primary insured has provided to the plan. Notice made in this manner is sufficient to preserve the plan's subrogation rights under this section. Such notice may alternatively be sent to an attorney representing the plan participant, and such notice is sufficient to satisfy this requirement.

(5) The plan may recover from plan participants, while living, any benefits incorrectly paid, as a debt due to the plan and, upon the plan participant's death, as a claim classified with taxes having preference under the laws of this state.

(c)

(1) By accepting payment of benefits pursuant to a plan authorized by this part, a plan participant has assigned to the plan the right of third party insurance benefits or other recovery rights to which the plan participants may be entitled.

(2) A plan under this part may deem a plan participant ineligible for continued or future coverage under the plan, where the plan participant has:

(A) Received payment from a third party tortfeasor, third party insurer, third party for medical payments, or other individual or entity originally paid by the plan for the benefit of, or on behalf of, the plan participant; and

(B) Failed or refused to promptly reimburse the plan for such amounts.

(3) The plan shall not remove a plan participant under a plan authorized by this part as provided under subdivision (c)(2) unless the plan or administrator provides the primary insured with written notice of intent to remove the plan participant. The plan or administrator shall send the notice at least ninety (90)

days prior to the date the plan participant will lose benefits under the plan and by certified mail with signed or electronic receipt. The notice must include, at a minimum, the following:

(A) The name of the plan participant to be removed from the plan;

(B) The date the plan participant will cease to be covered under the plan;

(C) The reason for removal from the plan; and

(D) The name, title, phone number, mailing address, and email address of an individual with the authority to cancel or change the plan participant's removal, if the removal violates the terms of the plan, or as the sponsor permits.

(4) The plan shall not prevent a provider from receiving payment for services already rendered to a provider even if the plan participant is removed from participation in a plan under subdivision (c)(2). However, this subdivision (c)(4) does not require the plan to pay benefits to medical services providers where such amounts have already been paid to a plan participant.

(d)

(1) A third party insurer or other third party, upon receiving a request from a plan, shall provide information identifying persons covered by third parties for medical services. As a condition of doing business in this state or providing coverage to residents of this state, and subject to subdivision (d)(3), a third party for medical services shall, upon request from a plan or an administrator, electronically provide full eligibility files that contain information to determine the period a plan participant may be or may have been covered by the third party. The eligibility files must also include the nature of the coverage that is or was provided by the third party; the name, address, date of birth, social security number, group number, and identifying number of the plan under which the plan

participant may receive benefits; and the effective and termination dates for the coverage.

(2) A third party is not liable to a policyholder for proper release to a plan or an administrator of the information contained in subdivision (d)(1).

(3) The third party shall provide the information described in subdivision (d)(1) upon receipt of written request from a plan or an administrator with the third party establishing confidentiality requirements for the information. Such request may be served on the third party electronically or by mail.

(4) Third parties shall respond to all written inquiries by a plan regarding a claim for payment for any healthcare item or service that is submitted not later than three (3) years after the date of the provision of the healthcare item or service, or within three (3) years of conclusion of litigation. Third parties shall respond to a plan's or administrator's request for payment by providing payment on the claim, a written request for additional information with which to process the claim, or a written reason for denial of the claim within ninety (90) days of receipt of written proof of loss or claim for payment for healthcare services provided to, for the benefit of, or on behalf of, a plan participant. Such notice may be sent to the plan electronically or by mail. Notwithstanding title 56, a failure to pay or deny a claim within one hundred eighty (180) days after receipt of the claim constitutes a waiver of any objection to the claim and an obligation to pay the claim.

(e)

(1) A plan shall list the address or addresses to which all notices required by this section must be sent in the plan document, in the SPD, and in all materials the plan provides to the primary insured regarding benefits under the plan, including information published on the internet or on a sponsor's intranet. The address must be an address that accepts certified mail.

(2) At each enrollment renewal period, the plan shall mail to each primary insured, at the primary insured's last address of record provided to the plan, an SPD that provides details about the current plan benefits. Additionally, to the extent that the sponsor maintains an intranet or other electronic portal for the benefit of its employees, such information must be readily available on this platform to all primary insureds under the plan.

(3) Before the entry of the judgment or settlement in a personal injury case, the plan participant or the plan participant's attorney, or other individual or the individual's attorney, who has an interest in recovery under this section, shall notify the plan in writing by certified mail, with return or electronic receipt, at the address provided in the SPD or plan document, requesting that the plan determine the amount, if any, of the plan's subrogation interest. The notice must, at a minimum, provide the plan participant's full name; date of birth; social security number, if known; and the date the plan participant's claim arose.

(4) Within ninety (90) days of receipt of the notice described in subdivision (e)(3), a plan having a subrogation interest shall respond to the individual who provided the notice in writing sent by certified mail, with either return or electronic receipt, providing either the amount of the subrogation interest or notice that additional time is necessary in order to determine the amount of the plan's subrogation interest. If additional time is necessary, a plan shall provide a response containing the amount of the subrogation interest within one hundred eighty (180) days of receipt of the notice described in subdivision (e)(3), unless treatment of the plan participant, or billing of the plan by medical services providers, is ongoing. If a plan or plan administrator notifies the plan participant or the plan participant's attorney that the plan is unable to provide the amount of its subrogation interest because treatment or billing is ongoing, the notification is a valid response, and the plan's subrogation interest is not extinguished. The plan participant or the plan participant's attorney shall bear the

burden of additional requests to the plan to ascertain the amount of the plan's subrogation interest. The plan participant or the plan participant's attorney shall then inform the court regarding the results of the notice, if any, to the plan. If the plan fails to respond within the period specified in this subdivision (e)(4), then the plan's subrogation interest is extinguished and disbursements may be made without recourse upon the plan participant or the plan participant's attorney, or other individual who may have an interest in such disbursements.

(5) If the plan participant or the plan participant's attorney received a timely response from the plan, but the amount of the subrogation interest remains in dispute, upon motion by the plan the trial judge shall hold a hearing in accordance with subdivision (e)(6). After trial and at the time of the entry of the judgment or settlement in a case in which the plan has a subrogation interest under this section, it is the responsibility of the trial judge to calculate the amount of the subrogation interest and incorporate the court's findings concerning the subrogation interest in the final judgment or settlement.

(6) The trial judge shall base the gross amount of the subrogation interest upon the findings of the trier of fact at trial concerning medical expenses and evidence introduced after the trial about the total sum of moneys paid by the plan for medical expenses for injuries arising from the incident that is the basis of the action. The trial judge shall reduce the gross amount of the subrogation interest by one (1) or more of the following factors, as applicable:

(A) To the extent that the plan participant plaintiff is partially at fault in the incident giving rise to the litigation, the subrogation interest is reduced by the percentage of fault assessed against the plan participant plaintiff;

(B) To the extent that the finder of fact allocated fault to a person who was immune from suit, the subrogation interest is reduced by the percentage of fault assessed against the immune person;

(C) To the extent that the finder of fact allocates fault to a governmental entity that has its liability limited under state law, and the fault of the entity, when multiplied by the total dollar value of the damages found by the finder of fact, exceeds the amount of judgment that can be awarded against the entity, the subrogation interest is reduced proportionately by a percentage derived by dividing the uncollectable portion of the judgment against the plan by the total damages awarded; and

(D) To the extent that the finder of fact allocated fault to a person that the plan participant plaintiff did not sue, the subrogation interest is reduced by the percentage of fault assessed against the nonparty.

(7) After the calculations described in subdivision (e)(6) are performed, the trial judge shall reduce the subrogation interest pro rata by the amount of reasonable attorneys' fees and litigation costs incurred by the plan participant plaintiff in obtaining the recovery.

(8) The amount determined from the calculations required under subdivisions (e)(6) and (7) is the net subrogation interest. If a plan participant plaintiff or the plan participant's attorney collects the judgment, each has the obligation to promptly remit the net subrogation interest and attorneys' fees and costs to any counsel employed by the plan, as required by the final judgment. If the plan participant plaintiff and the plan participant's attorney collect only a portion of the final judgment, each has the obligation to promptly remit a pro rata share of the net subrogation interest and attorneys' fees and costs to any counsel employed by the plan, as required by the final judgment. If the plan participant plaintiff and the plan participant's attorney later collect additional moneys against the judgment, there is a continuing obligation on both to remit a pro rata share of the moneys collected as required by the final judgment.

(9) If a plan participant plaintiff or the plan participant's attorney, or both, fails to timely remit to the plan's counsel the plan's pro rata portion of judgment moneys received, upon motion by the plan, the court shall award to the plan attorney's fees for the cost of the motion, interest on moneys withheld, as well as the amounts withheld, and may, in its discretion, order those who failed to timely release funds to forfeit to the plan all sums received in payment of the judgment.

(10) If the case between the plan participant plaintiff and the defendant is settled before trial and the parties and the plan are unable to reach an agreement on the amount of the subrogation interest, then the trial judge shall hold a hearing to determine the gross and net subrogation interests, taking into account the criteria listed in subsection (e)(6) and the likelihood of collecting any judgment against parties determined to be at fault. No expert foundation is required to prove any claimed damages. Any aggrieved party may appeal the court's decision.

(f) If a plan participant initiates suit against a plan or administrator for any action taken on behalf of the plan with respect to benefits under the plan, recovery is limited to accrued benefits due under the terms of the plan, a declaratory judgment on entitled benefits, or an injunction against a plan's or administrator's improper refusal to pay benefits. In no case shall such relief include damages, but it may include attorney's fees.

(g) It is the intention of the general assembly that subsections (d)-(f) be used in lieu of application of the "made whole" doctrine for any recovery authorized under this section. Subsections (d)-(f) apply to cases that have been settled when no lawsuit has been filed.

(h) The plan document must be made available to all plan participants for review, either electronically or in printed format, upon a plan participant's request.

SECTION 2. Tennessee Code Annotated, Section 8-27-608, is amended by deleting the section and substituting instead the following:

(a) As used in this section:

(1) "Administrator" means:

(A) An individual, either employed by, or contracted with, the sponsor or the plan to provide administrative services on behalf of the plan; or

(B) An entity with whom the sponsor contracts to provide administrative services on behalf of the plan;

(2) "Days" means calendar days, unless otherwise noted;

(3) "Insured" means any individual, other than the primary insured, who receives benefits under the plan;

(4) "Plan" means any self-funded plan established and funded by a sponsor pursuant to this part for the purpose of providing group life, hospitalization, disability, on-the-job injury or work-related injury program, or medical insurance, where funding for the plan is derived from local tax revenues, which are used to either fully, or in excess of fifty-one percent (51%), fund the total costs of the plan, and where such benefits are paid directly through the sponsor's general assets or through a trust fund established for that purpose. Self-funded plans include those plans to which the primary insured pays to the plan a nominal fee, not to exceed a total of ten percent (10%) of the total cost of coverage for the primary insured and any insureds whose relationship to the primary insured allows them to receive benefits under the plan. Whether or not the plan contracts with an administrator is not a factor in determining whether the plan meets this subdivision (a)(4);

(5) "Plan document" means a written instrument by which a plan is established and operated;

(6) "Plan participant" means either a primary insured or insured;

(7) "Primary insured" means the individual employed by, or contracted with, the sponsor and to whom, based on the individual's status as an employee or contractor, the plan provides benefits;

(8) "Settlement" means an agreement reached between a plan participant and a third party tortfeasor or the third party insurer, or both;

(9) "Sponsor" means any municipality, metropolitan government, or special school district within this state that establishes and funds a plan;

(10) "Subrogation interest" means the right to recovery that the plan has in any litigation or settlement arising from the injury or illness of a plan participant caused by a third party tortfeasor. "Subrogation interest" does not include pre- or post-judgment interest;

(11) "Summary plan description" or "SPD" means a summary of the plan document that includes, at a minimum, a summary description of all benefits and costs under the plan, including co-pays, deductibles and premiums for different tiers of coverage, if applicable; a list of eligible plan participants; contact information for the administrator; contact information for the sponsor; and a mailing address for each type of notice required by this statute;

(12) "Third party for medical services" or "third party" includes, but is not limited to, a health and liability insurer, an administrator of an ERISA plan, an employee welfare benefit plan, a workers' compensation plan, CHAMPUS, Medicare, and other parties that are by statute, contract, or agreement, legally responsible for payment of a claim for a healthcare item or service;

(13) "Third party insurer" means any insurer that provides insurance coverage to a third party tortfeasor, regardless of whether such coverage is personal or commercial, including, but not limited to, automobile, income replacement, premises liability, home owners, umbrella, group life, health, workers compensation, hospitalization, and disability; and

(14) "Third party tortfeasor" means an individual or entity who commits a tort against a plan participant that causes a plan participant to require medical treatment for which the plan makes payments to a provider of medical services for the benefit, or on behalf, of the plan participant.

(b)

(1) A plan shall not recover a medical payment paid to, or on behalf of, a plan participant, under a plan unless the medical payment has been incorrectly paid, or unless the plan participant recovers, or is entitled to recover, from a third party tortfeasor or third party insurer reimbursement for all or part of the costs of care or treatment for the injury or illness for which the medical payment is paid.

(2) The plan is subrogated to all rights of recovery against any person or entity for the cost of care or treatment for any injury or illness caused by a third party tortfeasor for which medical payment is provided, contractual or otherwise, by the plan for the benefit of, or on behalf of, a plan participant.

(3) The plan shall not withdraw or reduce payments to a provider of medical services in order to recover funds obtained by a plan participant from third party tortfeasors or third party insurers for medical services rendered by a medical services provider if the plan has reason to know that such funds were obtained without the knowledge or direct assistance of the provider.

(4) If the plan asserts its right to subrogation, the plan shall notify the primary insured, in language understandable to the primary insured, of the plan's rights of recovery against third parties and that the primary insured should seek the advice of an attorney regarding those rights of recovery to which the plan may be entitled. Such notice shall be made by certified mail, with a signed or electronic receipt, sent to the last address of record the primary insured has provided to the plan. Notice made in this manner is sufficient to preserve the plan's subrogation rights under this section. Such notice may alternatively be

sent to an attorney representing the plan participant, and such notice is sufficient to satisfy this requirement.

(5) The plan may recover from plan participants, while living, any benefits incorrectly paid, as a debt due to the plan and, upon the plan participant's death, as a claim classified with taxes having preference under the laws of this state.

(c)

(1) By accepting payment of benefits pursuant to a plan authorized by this part, a plan participant has assigned to the plan the right of third party insurance benefits or other recovery rights to which the plan participants may be entitled.

(2) A plan under this part may deem a plan participant ineligible for continued or future coverage under the plan, where the plan participant has:

(A) Received payment from a third party tortfeasor, third party insurer, third party for medical payments, or other individual or entity originally paid by the plan for the benefit of, or on behalf of, the plan participant; and

(B) Failed or refused to promptly reimburse the plan for such amounts.

(3) The plan shall not remove a plan participant under a plan authorized by this part as provided under subdivision (c)(2) unless the plan or administrator provides the primary insured with written notice of intent to remove the plan participant. The plan or administrator shall send the notice at least ninety (90) days prior to the date the plan participant will lose benefits under the plan and by certified mail with signed or electronic receipt. The notice must include, at a minimum, the following:

(A) The name of the plan participant to be removed from the plan;

(B) The date the plan participant will cease to be covered under the plan;

(C) The reason for removal from the plan; and

(D) The name, title, phone number, mailing address, and email address of an individual with the authority to cancel or change the plan participant's removal, if the removal violates the terms of the plan, or as the sponsor permits.

(4) The plan shall not prevent a provider from receiving payment for services already rendered to a provider even if the plan participant is removed from participation in a plan under subdivision (c)(2). However, this subdivision (c)(4) does not require the plan to pay benefits to medical services providers where such amounts have already been paid to a plan participant.

(d)

(1) A third party insurer or other third party, upon receiving a request from a plan, shall provide information identifying persons covered by third parties for medical services. As a condition of doing business in this state or providing coverage to residents of this state, and subject to subdivision (d)(3), a third party for medical services shall, upon request from a plan or an administrator, electronically provide full eligibility files that contain information to determine the period a plan participant may be or may have been covered by the third party. The eligibility files must also include the nature of the coverage that is or was provided by the third party; the name, address, date of birth, social security number, group number, and identifying number of the plan under which the plan participant may receive benefits; and the effective and termination dates for the coverage.

(2) A third party is not liable to a policyholder for proper release to a plan or an administrator of the information contained in subdivision (d)(1).

(3) The third party shall provide the information described in subdivision (d)(1) upon receipt of written request from a plan or an administrator with the

third party establishing confidentiality requirements for the information. Such request may be served on the third party electronically or by mail.

(4) Third parties shall respond to all written inquiries by a plan regarding a claim for payment for any healthcare item or service that is submitted not later than three (3) years after the date of the provision of the healthcare item or service, or within three (3) years of conclusion of litigation. Third parties shall respond to a plan's or administrator's request for payment by providing payment on the claim, a written request for additional information with which to process the claim, or a written reason for denial of the claim within ninety (90) days of receipt of written proof of loss or claim for payment for healthcare services provided to, for the benefit of, or on behalf of, a plan participant. Such notice may be sent to the plan electronically or by mail. Notwithstanding title 56, a failure to pay or deny a claim within one hundred eighty (180) days after receipt of the claim constitutes a waiver of any objection to the claim and an obligation to pay the claim.

(e)

(1) A plan shall list the address or addresses to which all notices required by this section must be sent in the plan document, in the SPD, and in all materials the plan provides to the primary insured regarding benefits under the plan, including information published on the internet or on a sponsor's intranet. The address must be an address that accepts certified mail.

(2) At each enrollment renewal period, the plan shall mail to each primary insured, at the primary insured's last address of record provided to the plan, an SPD that provides details about the current plan benefits. Additionally, to the extent that the sponsor maintains an intranet or other electronic portal for the benefit of its employees, such information must be readily available on this platform to all primary insureds under the plan.

(3) Before the entry of the judgment or settlement in a personal injury case, the plan participant or the plan participant's attorney, or other individual or the individual's attorney, who has an interest in recovery under this section, shall notify the plan in writing by certified mail, with return or electronic receipt, at the address provided in the SPD or plan document, requesting that the plan determine the amount, if any, of the plan's subrogation interest. The notice must, at a minimum, provide the plan participant's full name; date of birth; social security number, if known; and the date the plan participant's claim arose.

(4) Within ninety (90) days of receipt of the notice described in subdivision (e)(3), a plan having a subrogation interest shall respond to the individual who provided the notice in writing sent by certified mail, with either return or electronic receipt, providing either the amount of the subrogation interest or notice that additional time is necessary in order to determine the amount of the plan's subrogation interest. If additional time is necessary, a plan shall provide a response containing the amount of the subrogation interest within one hundred eighty (180) days of receipt of the notice described in subdivision (e)(3), unless treatment of the plan participant, or billing of the plan by medical services providers, is ongoing. If a plan or plan administrator notifies the plan participant or the plan participant's attorney that the plan is unable to provide the amount of its subrogation interest because treatment or billing is ongoing, the notification is a valid response, and the plan's subrogation interest is not extinguished. The plan participant or the plan participant's attorney shall bear the burden of additional requests to the plan to ascertain the amount of the plan's subrogation interest. The plan participant or the plan participant's attorney shall then inform the court regarding the results of the notice, if any, to the plan. If the plan fails to respond within the period specified in this subdivision (e)(4), then the plan's subrogation interest is extinguished and disbursements may be made

without recourse upon the plan participant or the plan participant's attorney, or other individual who may have an interest in such disbursements.

(5) If the plan participant or the plan participant's attorney received a timely response from the plan, but the amount of the subrogation interest remains in dispute, upon motion by the plan the trial judge shall hold a hearing in accordance with subdivision (e)(6). After trial and at the time of the entry of the judgment or settlement in a case in which the plan has a subrogation interest under this section, it is the responsibility of the trial judge to calculate the amount of the subrogation interest and incorporate the court's findings concerning the subrogation interest in the final judgment or settlement.

(6) The trial judge shall base the gross amount of the subrogation interest upon the findings of the trier of fact at trial concerning medical expenses and evidence introduced after the trial about the total sum of moneys paid by the plan for medical expenses for injuries arising from the incident that is the basis of the action. The trial judge shall reduce the gross amount of the subrogation interest by one (1) or more of the following factors, as applicable:

(A) To the extent that the plan participant plaintiff is partially at fault in the incident giving rise to the litigation, the subrogation interest is reduced by the percentage of fault assessed against the plan participant plaintiff;

(B) To the extent that the finder of fact allocated fault to a person who was immune from suit, the subrogation interest is reduced by the percentage of fault assessed against the immune person;

(C) To the extent that the finder of fact allocates fault to a governmental entity that has its liability limited under state law, and the fault of the entity, when multiplied by the total dollar value of the damages found by the finder of fact, exceeds the amount of judgment that can be awarded against the entity, the subrogation interest is reduced

proportionately by a percentage derived by dividing the uncollectable portion of the judgment against the plan by the total damages awarded; and

(D) To the extent that the finder of fact allocated fault to a person that the plan participant plaintiff did not sue, the subrogation interest is reduced by the percentage of fault assessed against the nonparty.

(7) After the calculations described in subdivision (e)(6) are performed, the trial judge shall reduce the subrogation interest pro rata by the amount of reasonable attorneys' fees and litigation costs incurred by the plan participant plaintiff in obtaining the recovery.

(8) The amount determined from the calculations required under subdivisions (e)(6) and (7) is the net subrogation interest. If a plan participant plaintiff or the plan participant's attorney collects the judgment, each has the obligation to promptly remit the net subrogation interest and attorneys' fees and costs to any counsel employed by the plan, as required by the final judgment. If the plan participant plaintiff and the plan participant's attorney collect only a portion of the final judgment, each has the obligation to promptly remit a pro rata share of the net subrogation interest and attorneys' fees and costs to any counsel employed by the plan, as required by the final judgment. If the plan participant plaintiff and the plan participant's attorney later collect additional moneys against the judgment, there is a continuing obligation on both to remit a pro rata share of the moneys collected as required by the final judgment.

(9) If a plan participant plaintiff or the plan participant's attorney, or both, fails to timely remit to the plan's counsel the plan's pro rata portion of judgment moneys received, upon motion by the plan, the court shall award to the plan attorney's fees for the cost of the motion, interest on moneys withheld, as well as the amounts withheld, and may, in its discretion, order those who failed to timely release funds to forfeit to the plan all sums received in payment of the judgment.

(10) If the case between the plan participant plaintiff and the defendant is settled before trial and the parties and the plan are unable to reach an agreement on the amount of the subrogation interest, then the trial judge shall hold a hearing to determine the gross and net subrogation interests, taking into account the criteria listed in subsection (e)(6) and the likelihood of collecting any judgment against parties determined to be at fault. No expert foundation is required to prove any claimed damages. Any aggrieved party may appeal the court's decision.

(f) If a plan participant initiates suit against a plan or administrator for any action taken on behalf of the plan with respect to benefits under the plan, recovery is limited to accrued benefits due under the terms of the plan, a declaratory judgment on entitled benefits, or an injunction against a plan's or administrator's improper refusal to pay benefits. In no case shall such relief include damages, but it may include attorney's fees.

(g) It is the intention of the general assembly that subsections (d)-(f) be used in lieu of application of the "made whole" doctrine for any recovery authorized under this section. Subsections (d)-(f) apply to cases that have been settled when no lawsuit has been filed.

(h) The plan document must be made available to all plan participants for review, either electronically or in printed format, upon a plan participant's request.

SECTION 3. This act shall take effect July 1, 2020, the public welfare requiring it, and shall apply to plans entered into or renewed on or after that date.